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ABSTRACT

This booklet discusses four of the more common classroom behavior disorders with which teachers must deal: hyperactivity, childhood depression, extreme shyness, and aggressive behavior. In the section on hyperactivity, three characteristics--excessive motor activity, inattentiveness, and impulsiveness--are listed as constituting the hyperactivity syndrome. The term Attention Deficit Disorder is explained. A case study of a hyperactive child is presented, assessment of hyperactivity is discussed, causes of hyperactivity are considered, treatment is reviewed, and the prognosis for hyperactive children is described. The section on childhood depression presents a case study of a depressed child and addresses the issues of assessment, causes of childhood depression, and intervention strategies. Case studies, assessment techniques, causes, and intervention strategies are also described for the disorders of extreme shyness and aggressive behavior. References are included. (Author/NB)

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FASTBACK

245

Dealing with Abnormal Behavior in the Classroom

David M. Romney

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Dealing with Abnormal Behavior in the Classroom

by
David M. Romney

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Introduction

A number of children's psychological disorders not only have a detrimental effect on the child's classroom performance but also can be disruptive or disturbing to other children. This fastback will discuss four of the more common behavior disorders with which teachers frequently must deal: hyperactivity, childhood depression, extreme shyness, and aggressive behavior.

Some children seem to lack self-control; they move about excessively, act on impulse, and are easily distracted. These hyperactive children, as they are called, are a constant nuisance and source of concern to their parents and teachers and are irritating to their peers. Aggressive students, who frequently get into fights, bully younger children, defy their elders, and cause damage to property, also pose a problem. On the other hand, there are children who appear just the opposite; they are pathologically shy, too embarrassed to express themselves in class, and unable to make friends or mix easily in company. This social phobia can be a terrible handicap and can make the child's life miserable. Some children feel profoundly depressed, even suicidal, often for no apparent reason. The existence of childhood depression as a clinical entity and its possible unfortunate consequences have been acknowledged only recently.

It is important for the teacher to be able to recognize the nature of these disorders and to be aware of what remedial or administra-

tive action to take. Sometimes specialized help may be needed, and the child should be referred to a school or clinical psychologist. However, this step may not always be necessary if the teacher knows how to handle the child properly. A lot depends on the seriousness of the condition, as well as on the experience and skill of the teacher.

Hyperactivity

Perhaps the most disruptive of all childhood behavior disorders is hyperactivity. Hyperactive children are always "on the go." When seated, they fidget continuously; even during sleep they move about restlessly. In addition to their excessive, unfocused motor activity, hyperactive children are inattentive and impulsive. They seem incapable of listening and are easily distracted. They often fail to finish any project they start. Also, they act before thinking, frequently calling out in class and not waiting their turn in games.

These three characteristics, excessive motor activity, inattentiveness, and impulsiveness, constitute the hyperactivity syndrome. Psychiatrists call this syndrome Attention Deficit Disorder or ADD (American Psychiatric Association 1980) in order to emphasize that disordered attention is the core symptom. But the term hyperactivity is more widely used.

Case No. 1: Hyperactivity*

Matthew is a 10-year-old, white, male child with ADD diagnosed at 6 years of age. He is superior in intellect (IQ = 135) but classified as "underachieving" at school because of failure to complete his assignments and pay attention to class lectures. His penmanship was often sloppy and he was poorly organized in approaching written tasks. He was frequently disruptive in class because of his frequent talking

without permission, leaving his desk at inappropriate times, and frequent playing with objects or toys not relevant to the immediate task. Socially, Matthew had no consistent group of friends or playmates. Immature conduct, silliness, and selfishness usually repelled most children, and he was often depressed over his position as a social outcast. At home, severe problems with noncompliance, poor attention span, disrespectful behavior to parents, and poor sibling interactions were chronic. His parents were beginning to doubt their ability to raise this adopted child and still care for the adopted, younger daughter in the family. Matthew was also being evaluated at his school for a possible change to a smaller class for emotionally disturbed children.

*Copyright 1983. Reprinted with permission from Barkley, R.A. "Hyperactivity." In *The Practice of Child Therapy*, edited by R.J. Morris and T.R. Kratochwill. New York: Pergamon Press.

The prevalence of hyperactivity is generally estimated to be between 4% and 5% of school-age children (Barkley 1981), though estimates vary from as low as 1% to as high as 20% (Ross and Ross 1982). Most commonly, referrals for hyperactivity are made for children aged between 8 and 12, with boys usually outnumbering girls by at least three to one. Hyperactive children come more often from lower socioeconomic groups, and there is some evidence that the disorder is hereditary (Routh 1978).

Because hyperactivity interferes with learning, these children often fail to realize their academic potential; and despite their normal intelligence, they may find themselves considerably behind at school. In fact, it has been suggested by Sandoval (1982) that 40% to 50% of hyperactive children will be classified as learning disabled.

Assessment

Because hyperactivity usually is not observed directly by a clinician, the diagnosis often is based on teachers' and parents' reports. Usually these reports corroborate each other; but when they conflict, the teacher's opinion usually is given more credence. Teachers are more objective because they have more bases for comparison, and their opinions can be quantified by using such instruments as the Conners

Teacher Rating Scale. The original version of this scale (Conners 1969) contains 39 behavioral items on which the teacher rates the degree of activity from none at all (scored 0) to very much (scored 3). These items cover classroom behavior, group participation, and attitude toward authority. An abbreviated version of the scale (see below) with only 10 items has been developed (Conners 1973).

Conners Abbreviated Teacher Rating Scale

Child's Name _____ Code Number _____
Study Number _____

Teacher's Observations
Information obtained _____ by _____
month day year

Observation	Degree of Activity			
	Not at all	Just a little	Pretty much	Very much
1. Restless and overactive				
2. Excitable, impulsive				
3. Disturbs other children				
4. Fails to finish things he starts – short attention span				
5. Constantly fidgeting				
6. Inattentive, easily distracted				
7. Demands must be met immediately – easily frustrated				
8. Cries easily and often				
9. Mood changes quickly and drastically				
10. Temper outbursts, explosive and unpredictable behavior				

Other Observations of Teacher

A child's score on this scale can be compared with normative data collected by Werry, Sprague, and Cohen (1975) to find out if the child is hyperactive. It is important to make this comparison to avoid being misled by individual impressions. For instance, a very strict teacher who is unable to tolerate the slightest disturbance in class might tend to classify children as hyperactive when they are not, whereas another teacher might fail to identify hyperactive children. By having a reference group for comparison, a more objective judgment can be reached.

There are a number of other standard psychological tasks that can be used to assess hyperactivity. A good example of such a task is Kagan's Matching Familiar Figures Test (1966), which was designed to measure impulsiveness. The child has to select one picture out of six variants that is exactly like the model picture. Hyperactives respond faster and make more errors than normal children (Salkind 1977).

Causes of Hyperactivity

The cause or causes of hyperactivity are not yet known, and the various theories that have been proposed seem to provide only a partial explanation. According to one theory (Wender 1971), hyperactive children are supposed to suffer from minimal brain damage. This theory is based on the observation that brain-damaged individuals have features in common with hyperactive children, in particular, high distractibility and lack of self-control. Furthermore, some hyperactive children respond well to medication, thus tending to confirm its organic origin. But despite the plausibility of this theory, no firm evidence has been produced to support it; and it is currently out of favor.

Another theory of the biological causes of hyperactivity is that it is hereditary; hyperactive children may have parents who were themselves hyperactive (Morrison and Stewart 1971). The possibility that hyperactivity may be transmitted genetically is in need of further, carefully controlled research. In addition, various physical agents (for example, lead, sugar, allergenic or toxic foodstuffs, and fluorescent lighting) also have been implicated in hyperactivity. However, research on these agents has not resulted in any firm conclusions. So far no psychological or social causes have been discovered, although there is little doubt that hyperactivity can be alleviated by psychological techniques.

Treatment for Hyperactivity

In some cases, hyperactivity paradoxically can be treated with such stimulant drugs as Ritalin or Cylert. At one time the effectiveness of these drugs appeared to be so convincing that hyperactive children who did not respond to them were considered to be misdiagnosed. However, many children who definitely are hyperactive do not respond to these drugs, while the performance of normal children is affected by these drugs (Rapoport et al. 1975).

There are several problems with treating hyperactivity with drugs. After the effect of the drug has worn off, there is an undesirable rebound effect. Moreover, the improvement due to the drug seems to be restricted to social behavior and is not reflected in academic performance (Barkley and Cunningham 1978). However, a recent study has shown that academic gains can be achieved if the drug is administered at half the usual dose (Varley and Trupin 1983). Another problem with using drugs to treat hyperactivity is that hyperactive children, who barely are tolerated by their classmates at the best of times, often are cruelly teased when known to be on medication. For these reasons, the use of drugs to treat hyperactivity has become less popular.

Perhaps the most successful treatment is self-instruction (Meichenbaum and Goodman 1971), in which hyperactive children are trained to obtain verbal control over their cognitive performance. The idea was inspired by the theory put forward by Luria (1961), the celebrated Russian physiologist, that language serves to inhibit motor activity in the normal child.

The procedure can be divided into distinct phases. First, the adult performs the task while verbalizing what he is doing. Next, the child performs the task under the supervision of the adult, who provides a running commentary on the child's actions. Then the child performs the task by himself, describing out loud what he is doing. Finally, the child carries out the task while instructing himself in a whisper, which gradually fades completely into silence, that is, becomes internalized as thought. Frequently, the child is taught to reinforce himself at the end by telling himself what a good job he did. Meichenbaum's approach has had a major impact on the treatment of hyperactivity, and there is mounting evidence that its beneficial effects generalize to scholastic achievement and endure over time (Kendall 1982).

An alternative treatment uses relaxation procedures to calm down the hyperactive child. By applying a procedure known as progressive muscle relaxation (PMR), which involves tensing and relaxing various sets of muscles in a systematic fashion, a more relaxed state can be attained. Another way of achieving relaxation is by means of biofeedback training, self-control of one's psychophysiological state with the aid of visual or auditory cues. For instance, the degree of tension in the muscles is measured by an electromyograph (EMG), and the information is "fed back" to the individual as a light or sound. Braud (1978) studied the separate effects of PMR and EMG biofeedback training on 15 hyperactive children and found that their symptoms were alleviated considerably by either procedure. However, this approach has been criticized as a mere palliative by Mash and Dalby (1979) because it is not directed at the primary deficit in hyperactivity, namely, inattentiveness.

While these remedial techniques can be used with individuals, it may be more practical to treat hyperactive children as a group. Barkley, Copeland, and Sivage (1980) trained a group of six hyperactive children in self-instruction and other self-control techniques over a period of six weeks. They were so impressed by their results that they concluded, "the ease with which these techniques were applied using academic and social problems in a classroom-like setting, as well as their efficacy at behavior management with minimal disciplining by teacher, argues strongly for their adoption by special programs for hyperactive children." Kendall and Zupan (1981) also found that self-instruction is equally effective whether training individuals or groups.

Sandoval (1982) recommends self-instruction as an effective classroom method. He particularly commends Douglas' (1980) program in cognitive training, which supplements self-instruction with helping the child understand his deficits and strengthening his motivation and capacity to adopt a problem-solving strategy. Sandoval also recommends biofeedback, which he admits may be "a bit exotic for the classroom teacher," and videofeedback, which shows the child just how inefficient and irritating his behavior actually is. He also suggests the following:

1. Modify target behavior, for example, staying in seat, by rewarding successive approximations (see fastback 221 *Changing Behavior: A Practical Guide for Teachers and Parents*);

2. Inhibit motor activity by giving children practice in varying their speed of response so as to increase their control over voluntary movements;
3. Reduce restrictions on movement, that is, find such substitute outlets for motor activity as push ups;
4. Use study carrels to shield hyperactive children from distraction;
5. Modify the pace of the classroom by using short lessons and short assignments;
6. Form appropriate attitudes by helping the children see that effort on their part can result in successful performance;
7. Set clear limits on behavior by making explicit to children what is acceptable;
8. Create an emotionally supportive atmosphere by showing genuine concern and caring;
9. Use role playing by having children enact a part that is different from their usual role in the classroom.

Prognosis

What happens to hyperactive children as they grow up? During adolescence their excessive motor activity diminishes, but they still are distractible and impulsive. Their school work continues to suffer, and they are prone to antisocial behavior and to depression arising from low self-esteem.

There are differences of opinion about how well they function as young adults. According to Borland and Heckman (1978), hyperactive adolescents improve considerably once they have left school; but according to Hechtman and Weiss (1983), they remain poorly adjusted. Further follow-up studies on reliably diagnosed samples are needed to resolve these contradictory findings.

Childhood Depression

Virtually every teacher has come across children who are depressed. They look dejected, have a low opinion of themselves, are apathetic, and are pessimistic about the future. They are poorly motivated, and 71% of them likely will be underachievers (Colbert, Newman, Ney, and Young 1982). But because their behavior is not disruptive, they often do not obtain the kind of attention they require.

Case No. 2: Depression*

Elliot was referred by his school at age thirteen years because of poor concentration on his work. He had had an excellent scholastic record at his primary school and was in the upper half of the top stream in his first year at grammar school. Then over the course of about eighteen months his work fell off badly and at the time of referral he was bottom of the lowest stream with marks ten per cent below the next lowest boy. He had become increasingly unhappy and often cried. He was tearful if spoken to sharply, no longer seemed to enjoy life, had given up his hobby of chemistry, was badly teased at school and had become increasingly reluctant to attend. Homework took longer and longer and at the time of referral was taking four hours. At school his relationships with other boys were poor, he participated poorly in group activities and had become increasingly shy and withdrawn, seeming in a perpetual daydream. At home he mostly sat around and took hours to get off to sleep at night.

The parents were very non-intellectual people who did not share Elliot's interests. Father was a quiet, passive man and mother was an assertive, capable, rather masculine woman. The marriage was not very happy and father was prone to bouts of depression. When seen at the clinic, Elliot was distant and unresponsive, speaking slowly with long silences. He was a tall, gangly, awkward boy who looked a caricature of the "intellectual." He hesitantly described feeling extremely miserable. Psychological testing showed him to have superior intelligence.

*Copyright 1975. Reprinted with permission from Rutter, M. *Helping Troubled Children*. London: Penguin Education.

Until fairly recently, stemming from the psychoanalytic viewpoint that a child's superego or conscience is not sufficiently developed to experience guilt, the very existence of childhood depression was in doubt (Rie 1966). Even now there is a belief that depression in children is a normal, transitory phenomenon of little clinical importance (Lefkowitz and Burton 1978), a belief that has been strongly challenged by Costello (1980). Another view that still enjoys a certain measure of support is that although depression does exist as a separate syndrome in children, it manifests itself very differently than in adults; and such recognizable symptoms as sadness and loss of interest may be "masked" by others not commonly considered to be signs of depression, for example, hyperactivity, school phobia, delinquency, psychosomatic illness, and so on (Leon, Kendall, and Garber 1980; Morris 1981).

Currently the most widely held view of childhood depression is that it is essentially similar to adult depression with some minor differences because of the child's lack of maturity (Kaslow and Rehm 1983). In other words, the feelings of sadness and apathy must be present for the diagnosis to be made; and the other symptoms, such as disobedience, are regarded as "associated features."

If severe depression goes unnoticed and untreated, it can lead to suicide attempts (Garfinkel, Froese, and Hood 1982). Suicide has been ranked as the fourth leading cause of death among teenagers in the United States (Crumley 1982). Therefore it is very important to detect abnormal depression early and to refer all suspected cases (see fastback 234 *Teenage Suicide: What Can the Schools Do?*). How-

ever, a teacher's judgment based on observation alone is not reliable, and reticent children who actually are depressed might be misdiagnosed as socially inhibited. In order to avoid overlooking depressed cases, it is far safer to rely on formal screening instruments.

Assessment

Probably the best known scale for assessing depression in children is the Children's Depression Inventory (CDI) constructed by Kovacs and Beck (1977). The CDI is a 27-item scale designed for children between 8 and 13 years of age. It is modeled on the well-known Beck Depression Inventory, the version used for adults and adolescents (Teri 1982). The interviewer reads the items aloud to the child, who then marks his or her answers directly on the inventory. Each item has three choices and is scored from 0 to 2, depending on the degree of depression expressed. Following is an example of one item:

I am sad once in a while.
I am sad many times.
I am sad all the time.

With 27 items, a total score of 54 is possible. A child who scores 19 or above is considered significantly depressed. This cut-off was chosen by Kovacs (1981) because she found that only 10% of children in the normal population scored as high or higher than this. The scale is highly reliable and correlates with clinical ratings of depression (.55) and with low self-esteem (.66).

Despite the excellent technical qualities of the CDI, a child's self-report may not be entirely valid (children sometimes hide their feelings); therefore, reports from parents and teachers also should be obtained.

Perhaps the best observers of a child's depression are his immediate peers. Working on this assumption, Lefkowitz and Tesiny (1980) developed a Peer Nomination Inventory of Depression (PNID) consisting of depression items (Who often plays alone?), happiness items (Who is often cheerful?), and popularity items (Who are the children you would like to have for your best friends?). Children with high

PNID scores from their peers also are perceived as depressed by their teachers and tend to rate themselves as depressed. Moreover, their achievement is lower and they miss school more often than children who are less frequently nominated.

While the CDI and PNID are useful as screening devices, they should not be substituted for interviews with the child by a psychologist or psychiatrist. Only these professionals are in a position to evaluate the severity of the symptoms and the urgency of the need for treatment. Teachers should refer appropriate cases to them.

Causes of Childhood Depression

There is some evidence that severely depressed children have biochemical abnormalities similar to those shown by severely depressed adults, that is, low levels of MHPG, a metabolite of the neurotransmitter norepinephrine, and high levels of the hormone cortisol (Lewis and Lewis 1981; McConville 1983). However, it is not clear whether these abnormalities are the cause or the effect of the depression.

Most research into the causes of depression has examined psychosocial factors, the major ones being parental loss, child abuse and neglect, and family psychopathology. Parental loss, which includes death, divorce, and desertion, has always figured as a prominent cause of depression in children (Poznanski 1979). Even the parents' withdrawal of interest because of remarriage, new siblings, personal preoccupations, etc., seems to be related to the onset of depression in children (Cytryn and McKnew 1972). Likewise, depression may develop if the child is physically neglected or is not exposed to enough socializing experiences. As might be expected, child abuse, especially sexual abuse, also has been identified as one of the principal causes of childhood depression (Blumberg 1981). Moreover, the emotional scars from this experience often linger into adult life.

Family psychopathology frequently has been found in the histories of depressed children. Poznanski and Zrull (1970) noted that many depressed children have parents who suffer from depression. So far no genetic link has been established, and it is assumed that either the children model themselves on their depressed parents or the parents

bring about depression in their children. A recent study comparing the children of depressed and nondepressed parents confirms that the children of depressed parents are more at risk not only for depression but also for other disorders (Billings and Moos 1983). Because of their vulnerability, these children should be prime targets of prevention programs.

Intervention

Severely depressed children may have to be treated with antidepressant drugs, although prescribing these drugs to children is not a widespread practice in North America. Usually, the child referred for depression will be treated by means of individual psychotherapy or, if the problem is due to parental rejection, by family therapy.

Milder cases of depression may be dealt with by the teacher in conjunction with a consultant. Butler and Miezitis (1980) have prepared a practical guide for teachers and consultants called *Releasing Children from Depression*, which includes 90 different strategies for dealing with maladaptive behaviors and other symptoms characteristic of the depressed child. Thus there are strategies for dealing with low self-esteem; withdrawn, uncommunicative behavior; aloofness; self-deprecating remarks; helpless/hopeless behavior; sadness; attention-seeking; negative peer relationships; and other problems. A few examples should serve to illustrate their approach:

> *Strategy #11 for Low Self-Esteem.* Assign a special job or responsibility to the child, either in the classroom or as a library or kindergarten or office assistant, etc. Be sure that the child is able to cope with the task. Convey the importance of the task to the child, and show your gratitude for his help. Give frequent verbal reinforcement as the task is accomplished.

> *Strategy #16 for Withdrawn, Uncommunicative Behavior.* Whenever the child raises his hand, whether to ask or answer a question, acknowledge it quickly. If he has to wait too long, he is likely to lower it! As the frequency of hand-raising increases, gradually extend the time before acknowledgment until it is consistent with that for other children in the class.

Strategy #26 for Helpless/Hopeless Behavior. Talk privately to the child about the impact of saying "I can't" or "I don't know" on his performance. These statements prevent attempts to work toward a solution. Perhaps the child could learn to say, "I will try" or "Maybe I can find out!"

Strategy #83 for Negative Peer Relationships. Model friendliness and warmth as much as possible in the classroom. The children will respond positively to this and will emulate you. Depressive children frequently spend a great deal of time watching the teacher and are good candidates for imitating your behavior.

The authors warn that the program "requires persistence and diligence . . . over an extended period of time." However, they assure us that "the rewards to the child are substantial." The program has not yet been evaluated by means of a carefully controlled outcome study; nevertheless, it does seem to be based on sound psychological principles and a good understanding of childhood depression.

Extreme Shyness

There are children who would very much like to interact with others but are too timid to do so because they lack the appropriate conversation or play skills or because they are afraid of being in the limelight and of being teased or shunned. As a consequence they tend to be outsiders, alone, without friends. Furthermore, they have frequent crying spells, are oversensitive to criticism, are easily discouraged, worry extensively, and show lack of enthusiasm and interest in their approach to tasks (Ross 1980).

Case No. 3: Shyness*

During the first days of school, Ann interacted freely with adults but seldom initiated contact with children or responded to their attempts to play with her. She did not seem severely withdrawn or frightened; instead she revealed a varied repertory of unusually well-developed physical and mental skills that drew the interested attention of adults but failed to gain the companionship of children. Teachers gave warm recognition to her skilled climbing, jumping, and riding; her creative use of paints and clay; her original songs and rhythmic interpretations of musical selections; her collections of nature objects; her perceptive and mature verbalizations; and her willing and thorough help with cleanup behaviors.

With passing days she complained at length about minute or invisible bumps and abrasions. She often spoke in breathy tones at levels so low that it was difficult to understand what she said. Her innumerable, bulky collections of rocks or leaves seemed to serve as "conversation pieces" valued only so long as they drew adult comments. She spent increasing time simply standing and looking. Frequently she retired to a make-believe bed in a packing box in the play yard to "sleep" for several minutes. Mild, tic-like behaviors such as picking her lower lip, pulling a strand of hair, or fingering her cheek were apparent.

After six weeks of school, a period considered ample for adjustment to the nursery school situation, the teachers made a formal inventory of Ann's behaviors and appraised the time she spent with children, with adults, and by herself. The evaluation revealed that Ann's behavior consisted of isolating herself from children and indulging in many varied techniques for gaining and prolonging the attention of adults. Close scrutiny further revealed that most of the adult attention given to her was contingent upon behaviors incompatible with play behavior with peers.

*Copyright 1964. Reprinted with permission from Allen, K.E.; Hart, B.; Buell, J.S.; Harris, F.R.; and Wolf, M.M. "Effects of Social Reinforcement on Isolate Behavior of a Nursery School Child." *Child Development* 35 (1964): 511-18.

Social isolation is also the fate of many hyperactive and aggressive children, but this is because they alienate everybody, including the teacher. In contrast, the shy child is not troublesome and is less likely to be perceived as needing special attention. There is evidence, however, that some shy children remain socially isolated as adults unless the problem is treated beforehand (Gelfand 1978). Cognizant of its seriousness, psychiatrists have included it in their classification scheme under the heading "Avoidant Disorder in Children and Adolescents" (American Psychiatric Association 1980). The element of anxiety is almost always present in social situations involving other children. By escaping from these situations the shy child's anxiety is diminished, so the child will try to avoid such situations whenever possible. This is the mechanism whereby a typical phobia is produced and strengthened; indeed, extreme shyness may be regarded as a social phobia.

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Assessment

Naturalistic observations of children in the classroom or playground will generally reveal those who are socially inhibited. Unlike the introverted child, who prefers being by himself and is often seen absorbed in a solitary activity, the shy child seems at a loss by himself and is often found on the periphery of a group, wishing to join in but not daring to.

A useful screening device for detecting socially withdrawn children in school is the Bristol Social Adjustment Guides (BSAG) developed by Stott (1970) for use by the teacher. Each guide consists of a large number of descriptive phrases, which the teacher underlines if they apply to the child being assessed. An alternative to having the teacher rate the child is to use a peer nomination sociometric technique, which provides a valid index of the child's peer acceptance. Shy children typically do not receive positive nominations.

Causes of Extreme Shyness

From a psychodynamic point of view, social withdrawal is a defense against overstimulation; because their parents fail to shield them from being overstimulated, shy children may have to erect barriers around themselves as a form of self-protection (Nagelberg, Spotnitz, and Feldman 1958). Behaviorists, on the other hand, argue that shyness is due to the anxiety and embarrassment experienced in social situations in the past, which may have been traumatic. By avoiding these situations, shy children are able to reduce their anxiety; but in so doing, they deny themselves the opportunity of ever learning the skills needed for successful socializing. Thus a vicious circle is created, which can be broken only by explicit intervention.

Intervention

The agonizing problem of shy children is their inability to interact with other children, not with adults. Some teachers are prone to lavish attention on such children in order to compensate for their isolation, thus subverting the shy child's need to play with other children.

The goal of any intervention plan should be increased peer interaction. This may be achieved through reinforcing the children with praise whenever they initiate or prolong social contacts.

The two other methods for helping withdrawn children are *modeling* and *assertiveness training*. O'Connor (1969) examined the effects of modeling on six shy nursery children who watched a film depicting a variety of social interactions between children followed by positive consequences. A female narrator described what the children in the film were doing and what fun they were having. Immediately after the film presentation, the children's peer interactions in their classrooms were much improved. Modeling also can be used profitably with older shy children if the behavior to be imitated and the vicarious rewards are age-appropriate. O'Connor's findings have been confirmed by Evers and Schwarz (1973) and Keller and Carlson (1974); but Gottman (1977) cautions that the reported modeling effects may have been due to an artifact resulting from improper observational procedures.

Modeling also has been combined with self-instruction in treating social isolates (Meichenbaum 1977). After being shown a film about how children initiate interactions, the shy children first rehearse out loud mimicking their instructor, then silently to themselves in a sequence of self-statements. These statements are essentially an inner soliloquy dealing with the following issues:

1. wanting to initiate interaction,
2. worrying about negative consequences,
3. the self-debate,
4. the moment of decision to go ahead,
5. the approach,
6. the greeting,
7. asking permission to join in (or requesting help).

This method is obviously more comprehensive than modeling alone and should lead to even better results.

Assertiveness training can be traced back a quarter of a century to Joseph Wolpe, one of the pioneers in the field of behavior therapy.

More recently, this kind of training has been advocated by leaders in the feminist movement. Shy children also are prime candidates for such training because of the difficulty they have in approaching others, their inability to stand up for their rights or to communicate their feelings of anger, and their tendency to be very acquiescent. The most common technique used in assertiveness training is role-playing. Using simulated situations that call for assertive behavior, the child and instructor play the principal parts. Sometimes the roles are deliberately reversed so the child can see how the instructor demonstrates assertiveness.

The Behavioral Assertiveness Test for Children (Bornstein, Bellack, and Hersen 1977) can be used not only to assess levels of assertiveness but also as an instrument for increasing assertiveness. It uses nine interpersonal situations with which children are likely to be confronted. The administration of the test involves an instructor narrating a scene followed by a prompt from an assistant sitting next to the child. After the child's response, the next scene is presented in the same way. The following example clarifies the procedure:

> *Narrator:* "You're part of a small group in a science class. You group is trying to come up with an idea for a project to present to the class. You start to give your idea when Amy interrupts to tell hers."
>
> *Prompt:* "Hey, listen to my idea first."

Then the shy child is supposed to persist with telling his idea.

An offshoot of assertiveness training has been developed by Whitehill, Hersen, and Bellack (1980) for children whose main deficit lies in conversation skills. The following directions are read to the child:

> "Hi, (child's name)! We are going to play a special kind of game now. I am going to read a description of a situation that might occur at school, something that you might find happen to you any time. Now, after I read the description of this situation, I would like you to begin a conversation with either Cindy or Doug (role models), who will be playing the parts of your classmates in the situation. I would like you to continue the conversation until I tell you to stop. OK?"

The instructor goes on to emphasize that while the situation is not real, and that Cindy and Doug are not really his classmates, the child should pretend that they are. The results of this method have been quite encouraging.

So far we have described techniques in which the shy child has to initiate social activity. Other researchers (Strain, Shores, and Timm 1977) have investigated the utility of having the child's peers interact with the shy child by demonstrating a game to him. This can lead eventually to an increase in the frequency of the shy child's spontaneous social behavior.

Aggressive Behavior

Overtly aggressive children are the most common referrals to mental health agencies, where they constitute one third to one half of all child referrals (Robins 1981). These children exhibit a variety of antisocial behaviors or "conduct disorders," which include violence, physical destructiveness, general unruliness, and delinquency. Not surprisingly, they are frequently in trouble at school for creating disturbances in the classroom and on the playground. Normal disciplinary measures may have little effect. The notion that it is good to allow such children to "let off steam" has fallen into disrepute. Ignoring antisocial behavior only perpetuates the habit of acting-out.

It is difficult to estimate the proportion of children in the population who could be categorized as "aggressive." All that can be said is that aggressive behavior is more common in boys than girls, and more common in adolescents than children.

Like the shy child, but for very different reasons, aggressive children tend to become social isolates, although they sometimes satisfy their need for companionship by becoming members of a gang. Longitudinal studies (Robins 1966) have shown that aggressive behavior remains stable over time; improvement does not seem to take place with maturity. Consequently, aggressiveness is not only associated with interpersonal and academic problems at school but also with maladjustment later in life.

Case No. 4: Aggression*

Dave was an 11-year-old Caucasian boy who was referred by a local mental health center to an inpatient psychiatric facility for evaluation and treatment. He was hospitalized because his parents felt they could no longer manage him at home given the severity and frequency of his aggressive behavior. Dave had a 6-year history of aggressive behavior, theft, and truancy. His aggressive acts were often severe. For example, on one occasion, his fighting led to the loss of vision in one eye of one of his classmates at school. At the time of admission, his current teacher feared her own welfare and refused to have him in class because of the physical abuse he inflicted on her. Hospitalization was precipitated in part by Dave's serious stabbing of his younger sister.

Apart from aggressive acts, Dave had a history of theft from stores, including small appliances and games and money from cash registers. Other problems were sporadic over his childhood including encopresis and enuresis, but they were associated with clear episodes of family stress (e.g., separation of the mother and father, death of a grandparent who had lived in the home). Although these problems had continued until his hospitalization, they were viewed as relatively minor in significance given the magnitude and consistency of his aggressive acts and rule breaking.

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Assessment

There is no difficulty detecting aggressive children; their behavior is hard to ignore. However, before one can start to devise effective strategies for controlling aggressiveness, a detailed assessment is required. The teacher should record what form the aggressive behavior takes (for example, hitting, yelling, threatening), exactly when and where it occurs, and what are its antecedents. In this way, the teacher can determine if the aggressive behavior is related to specific situations and settings, and what appears to trigger it. It is equally

important to note the consequences of the aggressive actions. How does the teacher respond? How do the other children react? What happens then? Only by obtaining a clear picture of the chain of events in which the aggressive behavior is embedded are we in a position to know how to intervene.

Besides direct, systematic observation, there are published rating scales that teachers can use to assess aggressive behavior. A well-known scale is the Walker Problem Behavior Identification Checklist (Walker 1970). This checklist contains 50 items, 14 of which deal with acting-out behavior. The items are weighted 1 to 4, depending on the severity of the behavior. Below are a few of the items with their respective weights, which will give the reader the flavor of the kinds of acting-out behavior identified on the checklist.

- Complains about others' unfairness and/or discrimination toward him (3).
- Argues and must have the last word in verbal exchanges (1).
- Does not obey until threatened with punishment (1).
- Openly strikes back with angry behavior to teasing of other children (3).
- Reacts with defiance to instructions or commands (1).

Causes of Aggressive Behavior

Although there is evidence from twin and adoption studies that antisocial behavior in general might be hereditary to some extent (Lytton, Watts, and Dunn 1984; Robins, West, and Herjanic 1975), the current emphasis has been on environmental factors and social learning. From a pragmatic point of view, it is easier to change an individual's environment than his genetic structure. One of the factors that has been implicated is parental discipline. Children of parents who tend to order them about and who punish them frequently and harshly are more likely to behave aggressively (Farrington 1978). Also, parental inconsistency in applying discipline has been linked with aggressiveness in the child (Hetherington and Martin 1979). Unsatisfactory family interaction in general appears to give rise to a host of childhood problems, including persistent, aggressive behavior.

A theoretical model proposed by Patterson (1982) to account for aggressiveness in children emphasizes the coercive nature of the parent-child interactions. Typically, these interactions start off with the parent asking the child to do something and the child refusing to obey and making a fuss. The parent may then give up (retracting the command) rather than listen to a whining, complaining child. As a result, the child's behavior is reinforced. Or the parent may insist, which leads to the child complaining even more vigorously. The interaction continues to escalate until the parent eventually gives up or the child complies. Over a long period of time these coercive behaviors become ingrained as ways of responding, as a result of continual negative reinforcement. But positive reinforcement also can shape aggressive behavior. For instance, when a parent responds to a child's temper tantrums with sympathetic attention, it tends to maintain the behavior.

While the preceding discussion is based on research in family interaction, it can explain equally well aggressive behavior in the classroom. The way a child interacts with the teacher also is influenced by both positive and negative reinforcement. Knowledge of these mechanisms can be turned to advantage in controlling a child's behavior.

Observational learning also may contribute to aggressive behavior. In their classic study, Bandura and Walters (1963) showed that children exposed to a film of an adult attacking a Bobo doll were subsequently much more likely to exhibit similar behavior toward the doll than a group of children who had not watched the film. If parents are always at loggerheads, the child is provided a model of aggression to imitate. Similarly, there is some evidence that violence on television can predispose viewers toward aggressive behavior either as a result of imitation or because they have become less sensitive to its harmful effects (Liebert and Schwartzberg 1977).

Intervention

The behavior of aggressive children can be modified by behavior modification techniques, although the desired result is not always achieved. In behavior modification, the behaviors to be changed must

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be precisely defined and assessed before proceeding with intervention. Actually, there are two target behaviors: 1) the aggressive behavior to be eliminated and 2) the more socially acceptable behavior to be substituted. The choice of positive reinforcer for accomplishing the latter should be appropriate for the child. Reinforcement such as praise may not be sufficient for aggressive children; sometimes material rewards have to be given. Tokens or points will do, provided they can be exchanged for something the child really values (backup reinforcers). Once the intervention begins to work, the reinforcement is gradually withheld (fading) so that the child does not come to rely on it.

Other techniques for dealing with aggressive behavior include time-out, response-cost, and overcorrection. Corporal punishment usually does not work with aggressive children, often making them even more aggressive. Time-out involves isolating the child for a brief, fixed period of time (from a few minutes to half an hour). The child should be told why he is being punished (for example, for hitting another child), otherwise other behaviors besides the target behavior may be suppressed. Response-cost is analogous to imposing a fine, in which previously acquired reinforcers such as tokens or points are deducted when aggressive acts occur. The more serious the offense, the stiffer the penalty (Kazdin and Frame 1983). Overcorrection has two components: positive practice and restitution. The aim is to guide the child kindly but firmly through the correct responses, physically directing him, if necessary, and obliging him to make amends for his misbehavior. For instance, if the child goes on a rampage and knocks over furniture, he must be made to put everything back in place and even tidy up areas he has not disturbed. Overcorrection is regarded as an efficient and efficacious means of reducing aggressive behavior (Matson, Stephens, and Horne 1978), although it should not be attempted unless the teacher is stronger than the child! In applying behavior modification to aggressive children, it is important to make sure that their parents are not countering one's efforts by inadvertently rewarding them for aggressive behavior (for example, encouraging them to "stand up and fight for their rights" without explaining that their rights can infringe on the rights of others or that disputes can be settled peacefully).

Modeling, discussed earlier in reference to the extremely shy child, also can be used with aggressive children when they are faced with a provoking situation. However, this approach cannot be incorporated as readily into routine classroom activities. The same practical drawback also applies to self-instruction training.

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Summing Up

Four different abnormal behaviors that occur in the classroom have been discussed separately, but this does not mean that they cannot occur together. Indeed, hyperactivity and aggressiveness often coexist; and extremely shy children are frequently lonely and depressed. Rather than diagnose a child as suffering from a single disorder, it is more realistic to assess several aspects of behavior in order to obtain a more comprehensive picture.

In discussing causes for particular disorders, several have been identified. However, these causes are not mutually exclusive and may often act in concert to produce the disorder. Similarly, different kinds of intervention have been described, but there is no reason why some of them cannot be amalgamated into a treatment package, which may prove to be more effective than any single treatment alone. Certainly, if one kind of treatment fails, we should be prepared to switch to another.

If children are to learn, teachers must be more than masters of their subject matter. Many children come to their classrooms who cannot learn until the kinds of problem behavior discussed in this fastback have been ameliorated. There are no simple solutions to these kinds of problems. Some, of course, are so severe that they require extended therapy. But teachers can do many of the things suggested in this fastback so that *all* children can learn.

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